Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING: _____ B. WING _____	04/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	Initial Comments A focused state re-licensure and infection control survey was conducted by the Office of Health Care Assurance on 04/30/2020. At the time of entrance, the facility's census included 99 residents. The facility was found to be in substantial compliance with Chapter 11-94.1, "Nursing Facilities" of the Hawaii Administrative Rules, at Sections 11-94.1-53 Infection control, 11-94.1-29 Resident abuse, neglect, and misappropriation of resident property, 11-94.1-36 Admission, transfer, and discharge, 11-94.1-39 Nursing services, and 11-94.1-58 Emergency preparedness. The facility was also found to be in compliance with 11-94.1-47 Adult day health services.	4 000		

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/08/20